



Rejuvenate Skincare and Laser

PATIENT PERSONAL INFORMATION

Date: _____

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Home Phone: _____ Cell Phone: _____

How did you hear about us?

☐ Friend ☐ Family Member ☐ Website ☐ Facebook ☐ Instagram ☐ Physician
☐ Other _____

PATIENT MEDICAL INFORMATION

Patient Medical History

Please check below if you have ever had or currently have any of the following (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergies to medication | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Anemia or bleeding problems |
| <input type="checkbox"/> Acne | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Eczema or atopic dermatitis |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Neuromuscular disorder | <input type="checkbox"/> Vitiligo |
| <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Abnormal moles |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Diabetes (Type 1/ Type 2) | <input type="checkbox"/> Autoimmune disorder | <input type="checkbox"/> History of keloids or thick scars |

The following questions are for female patients only

Are you pregnant? ☐ Yes ☐ No

Are you planning a pregnancy? ☐ Yes ☐ No

Are you on hormone treatments? ☐ Yes ☐ No

Please list all medications you are taking, including vitamins, pain relievers, and herbal remedies.

Please list any surgical procedures you have had.

Please list any other medical conditions or problems you may have that were not addressed.

SKIN QUESTIONNAIRE

Reason for today's visit?

Please answer the following questions.

Do you use a particular line of skincare products? List all skincare products used.

☐ Yes ☐ No _____

Do you use skincare products with alpha hydroxy, glycolic acid, retinol or a hydroquinone?

☐ Yes ☐ No If yes, what strength? _____

Have you had any experience with dermal fillers, injectables, or other types of cosmetic procedures (microdermabrasion, laser treatments, etc.)?

☐ Yes ☐ No If yes, please specify _____

Do you regularly apply sunscreen? ☐ Yes ☐ Only when outside ☐ Rarely ☐ Never

Do you have problems with healing? ☐ Yes ☐ No

Do you develop skin rashes in reaction to any of the following? (check all that apply)

☐ Medications ☐ Food ☐ Environment ☐ Other _____

If you answered yes to any of the above please explain:

SKIN TYPING WORKSHEET

Patient Name: _____ Date: _____

SCORE		0	1	2	3	4
	What is the color of your eyes?	Light Blue or Gray	Blue or Green	Hazel, Light Brown	Dark Brown	Brownish Black
	What is your natural hair color?	Red, Sandy Red	Blonde	Dark Blonde, Chestnut, Brown	Dark Brown	Black
	What is the color of your skin (unexposed areas)?	Reddish	Very Pale	Pale with Beige tint	Light Brown	Dark Brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had burns
	To what degree do you turn brown?	Hardly any or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	How often is the area you want to have treated exposed to the sun?	Never	Hardly ever	Sometimes	Often	Always
Add above column for Total Score:	Match your Total Score with the corresponding Skin Type:	Fitzpatrick Skin Type				
	0-7	I				
	8-16	II				
	17-25	III				
	26-30	IV				
	Over 30	V-VI				



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CANCELLATIONS AND MISSED APPOINTMENTS

STATEMENT OF POLICY

This policy enables us to better utilize available appointments for all patients.

REASON FOR THIS POLICY

Our goal is to provide quality care in a timely manner to all. Appointments are in high demand and early cancellation will give another person the opportunity to have access to timely care.

NON-EMPLOYEE APPOINTMENT:

If a patient has a scheduled appointment and needs to cancel or reschedule, they must call The Skincare and Laser Center staff at least 24 hours in advance of their appointment time. A fee up to the cost of the service or \$100, whichever is lower, will be assessed if the patient fails to cancel or reschedule per policy. A second occurrence will require the patient to pay for services in full at time of booking the appointment and the total cost will be non-refundable.

All new Skincare patients that schedule an Esthetician service will require a \$25.00 non-refundable appointment deposit, that will get applied to their service.

Print Name _____ Date _____

Signature of Patient _____



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ACKNOWLEDGEMENT OF PATIENT PRIVACY PRACTICE NOTICE

I have been informed of The Plastic Surgery Center's Patient Privacy Practices. I am aware that this notice describes how medical information about patients may be used and disclosed and how I can get access to this information. I have been requested to review it carefully. I am aware that I have the right to a paper copy of this notice and may ask for a copy at any time. I may obtain a paper copy of this notice by asking a staff member at the front desk or writing to: **The Plastic Surgery Center, 95 Scripps Drive, Sacramento, CA 95825.**

I am also aware that my Medical Record may be used in examination, testing, credentialing and/or certifying purposes by The American Board of Plastic Surgery, Inc.

Print Name _____ Date _____

Signature of Patient _____

I authorize The Plastic Surgery Center and Rejuvenate Skincare and Laser to release medical information pertaining to my care with the following people other than myself. I will assume responsibility to notify The Plastic Surgery Center or Rejuvenate Skincare and Laser, in writing, whenever this information changes.

Please think about listing the following people on this form:

- Spouse/Parent/Significant other
- Person providing transportation to and from appointments
- Person caring for you after surgery
- Anyone you may ask to obtain appointment information

Name _____ Relationship _____

Name _____ Relationship _____

Signature of Patient _____ Date _____ Acct. # _____



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DIGITAL MEDIA CONSENT AND RELEASE FORM

I, _____ (patient name) hereby agree and consent to Rejuvenate Skincare and Laser as follows.

A. I consent and authorize Rejuvenate Skincare and Laser to use my likeness in any photograph, video, or other digital media taken or to be taken during my appointment(s), in any and all of its publications, including print or web-based publications.

B. I irrevocably authorize Rejuvenate Skincare and Laser to copy, edit, enhance, crop, or otherwise alter any digital media for use in their publications. I also waive any rights for approval or inspection of any digital media taken of me.

C. I understand and agree that all digital media including photos and videos are the property of Rejuvenate Skincare and Laser and will not be returned to me.

D. I acknowledge that I am not entitled to any compensation or royalties with respect to the use of any digital media.

E. I agree to release and forever discharge Rejuvenate Skincare and Laser and its affiliates, successors and assigns, officers, employees, representatives, partners, agents, and anyone claiming through them, in their individual and/or corporate capacities from any and all claims, liabilities, obligations, promises, agreements, disputes, demands, damages, causes of action of any nature or kind, known or unknown, which I, and anyone claiming on behalf of me, may have or claim to have against the Releasee in connection with this release.

F. I have carefully read and fully understand all the provisions of this Digital Media Consent and Release Form and am freely, knowingly, and voluntarily signing.

Client Signature _____ Date _____

Witness _____



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E-COMMUNICATION

In response to the many requests for information regarding our practice, we are implementing E-communications with our patients. If you are interested in keeping up with information regarding events, new products or treatments and special savings from our practice, please provide your email below and we will add you to our database.

Your email is confidential and it will not be shared outside our practice.

Name: _____

Email Address: _____

By providing this information I give permission to the office of Rejuvenate Skincare and Laser and its affiliates permission to contact me via the email address provided above.